Chapter

Title: Learning to keep patients safe

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Introduction

The focus in this chapter is on the experiences of student nurses and newly qualified nurses (NQNs) transition into independent practice and their learning from and in practice. In an investigation into NQNs' ability to re-contextualise knowledge to allow them to deliver, organise and supervise care (Magnusson et al., 2014), Allan et al. (2017) found that NQNs progressively put knowledge learnt in university to work by drawing on interconnected domains of learning including embodied and emotional knowledge. These projects found that attaining competence during the transition period to confident professional is underpinned by knowledge re-contextualisation (Evans et al., 2009).

Findings from the project which investigated the effects of academic award on registered nurses' ability to re-contextualise knowledge to allow them to deliver, organise and supervise care (Magnusson et al. 2014), referred to hereafter as Study 1 are drawn on to illustrate arguments in this chapter

Pearson et al. (2014) investigated formal and informal ways pre-registration students, from a range of healthcare professions, learn about patient safety in order to become safe practitioners. This project sought to identify, describe and understand issues which impact upon teaching, learning and practicing patient safety in the academic, organisational and practice 'knowledge' contexts. The project concluded that a number of tensions and paradoxes exist across the academic, organisational and practice contexts which influence practice learning about patient safety and impact upon students 'emotional safety' for learning. This study is referred to hereafter as Study 2 in this chapter.

In this chapter, extracts from Studies 1 and 2 are used to illustrate that students and NQNs need emotional safety in order to re-contextualise or learn across knowledge contexts – learning is the production of new knowledge, which allows students and NQNs to develop in their journey

to independent and competent practice as a registered nurse. The chapter concludes by showing how safe challenge in the clinical learning environment can contribute to the development of a skilled reflective professional.

Workforce changes in increasingly complex nursing teams

The demand for nurses able to manage complex clinical nursing teams is predicted to increase due to an ageing population with more people suffering from long-term, manageable conditions (Shin et al., 2006; Worrell, 2007). Caring for patients with long-term conditions will become as important to the health service as delivering new technological advances (Dawoud & Maben, 2008;). However, there are acute nurse shortages globally and as a result, nurses are increasingly delegating tasks to unregistered health care staff due to rising healthcare costs, the need to maximise resources, skills-mixes, and the general expansion of health workers' roles (Weydt, 2010; Gillen & Graffin, 2010).

To prepare for the rising demand for nursing, the UK Government has said that nurses, equipped with critical thinking skills, will increasingly take up leadership positions to meet these challenges in future healthcare and delegate care to unregistered nursing assistant workforce. In the UK, this expanded care workforce will comprise the existing HCSWs at different bands of competency, including nursing associates and nursing apprentices. This ambitious nursing leadership agenda will be achieved through a number of policy changes:

- A career framework to retain highly skilled nurses in the workforce (Department of Health [DH], 2007);
- The introduction of all undergraduate pre-registration programmes (Nursing and Midwifery Council [NMC], 2010) which was itself shaped by Lord Willis' Review of the Future Education and Training of Registered Nurses and Care Assistants.
- The latest proficiency and education standards: Future Nurse: Standards of proficiency for registered nurses (NMC, 2018a), Standards framework for nursing and midwifery (2018b), Standards for preregistration nursing programmes (2018c).

At the heart of these policy strands is the aspiration for nurses who are prepared prior to registration to manage care and lead changes within health services through appropriate delegation and teamwork. Delegation is closely related to other concepts, such as responsibility, accountability and authority (Weydt, 2010). Cipriano (2010) maintains that delegation is an underdeveloped skill among nurses which is difficult to assess as it relies on

personality, communication style and mutual respect between the registered nurse and the care assistant.

Theoretical framework: re-contextualisation, emotions and learning and knowledge contexts

In this chapter three theoretical frameworks are synthesized: (1) re-contextualisation (Evans et al., 2011), (2) emotions and learning (Allan 2011) and (3) knowledge contexts (Steven 2009), to discuss how student nurses and NQNs learn to keep patients safe while feeling safe themselves in their own learning.

(1) Re-contextualisation

The knowledge re-contextualisation perspective introduces fresh thinking about the theory-practice relation by recognising that all the forms of knowledge that come together at the point of registration have been re-contextualised, that is, changed in the move from one context to another (e.g.: university, clinical placements) to serve a new purpose. Evans et al. (2010) approach concentrates on different forms of knowledge that students learn from and the ways in which these are contextualised and 're-contextualised' in movements between different sites of learning in colleges and workplaces. In Study 2, it was recognised that NQNs continue re-contextualising knowledge during the early days as a registered nurse.

Emotions and learning in nursing practice

Drawing on a psychodynamic theory where emotions are fundamental to all human interaction and contact (Menzies-Lyth, 1970; Fabricius, 1995), Allan (2011,) has proposed using a psychodynamic approach to emotional learning in nursing curricula or learning to work with feelings. She suggests that feelings shape learning both consciously and unconsciously in interactions with patients, their families and colleagues. She shows how supervision can assist students to integrate theory and practice through guided reflection on feelings arising from their learning in placements in small group work with a skilled teacher and /or tutor who works psychodynamically (Allan & Parr, 2010; Allan, 2011).

Learning to work with feelings means that the nurse is aware that as well as the clinical dimension of delivering care, there are also social and emotional processes at work in interactions with patients (and one could argue other practitioners) which affect how we feel (Fabricius, 1991a). Sometimes nurses are aware of these feelings and can reflect in action —

this means nurses are able to recognise the patient's feeling and their own responses and act appropriately. A concept with some similarities to *reflection-in-action* is 'reflexivity*'* (Iedema, 2011). Unlike reflection-in–action which is personal, in relation to patient safety Iedema (2011) describes reflexivity as more collaborative in nature, and the 'capacity to monitor and affect events, conducts and contexts in situ*'*.

However sometimes nurses can only reflect on action, i.e. after the event and learn from that reflection to work differently in similar situations in the future. These feelings are frequently buried and although they shape action, are not processed or learnt from. More worryingly, emotions are frequently buried as there is no-one with whom students can easily process them (Fabricius, 1991a, b; Rondahl et al., 2004; Allan & Parr, 2010).

Several studies have highlighted the need for emotions to be managed by students if they wish to 'fit' into a clinical placement or ward culture during their often short placements (Allan et al., 2011; 2017; Borrott et al., 2016; Bickhoff et al., 2016; Steven et al., 2014; 2009; Pearson et al., 2009; Levett–Jones et al., 2008; 2009a,b). Students become reluctant to rock the boat and learn to manage themselves to fit in; Steven et al. (2014) argue that this arises from a lack of 'emotional safety for learning' (ESFL). Drawing on data from Study 1: a large patient safety education research project (Pearson et al., 2009), Steven expanded her analysis of emotions and identified situations which lacked 'emotional safety for learning' (Steven et al., 2014). In later research regarding qualified nurses undertaking continuing professional development Steven identified some core elements of ESFL (Steven et al., 2018).

Knowledge contexts

Steven's work is a further development of these ideas around the interplay between context, here referred to as *knowledge contexts (KCs),* emotions and learning where she develops a framework for understanding student nurse's learning in practice as 'emotional safety for learning'. Students traverse a series of knowledge contexts during their education and while contexts are sometimes viewed as purely geographical locations, Steven et al. (2014) conceptualise knowledge contexts as much more. Drawing on the work of Eraut (1994) KCs can be identified as pertaining to: *organisational* (health care organisations such as NHS trusts), *academic* (universities or colleges) and *practice* (ward or team level of day to day practice) (Steven et al., 2014; Pearson et al., 2009). Although these KCs sometimes share

physical locations they hold different perceptions of what is valuable in terms of knowledge types and ways of working. For example, a health care organisational KC encompasses managerial, human resource, work flow processes, policies and so on. This KC could be defined as bureaucratic and concerned with systems, targets and procedures. Thus the organisational KC values knowledge which may partially draw on empirical evidence, but which is legitimised and 'verified' through stakeholder support, agreement and consensuses (for example policies and strategies).

The academic KC is predominantly based in, or informed by, research and higher education and privileges scientific 'evidence' and theory based on empirical work (often traditional science) and validated by 'experts'. The Academic KC is underpinned to a large extent by technical rationality (Schon, 1991; Usher et al., 1997; Steven, 2009) and is concerned with imparting 'evidence-based' knowledge, theory and techniques. This KC aims to have students reach certain thresholds on qualification- knowledge, theory and technique levels as measured by tests and examinations, and underpinned by 'robust' evidence. The practice KC is characterised by traditions, routines and accepted ways of working and values mainly experiential knowledge developed through everyday 'doing' and transmitted through working together (Eraut, 1994; Steven, 2009). While the practice KC (and organisational KC to a certain extent) espouse 'evidence-based' practice, the everyday concern within both is 'getting the work done' and drawing on what appears to 'work'. Thus, value is placed on qualitative, narrative 'craft' knowledge from both individual and shared practitioner experience (Usher et al. 1997; Steven 2009). Such knowledge is 'validated' by personal and/or group judgement (Steven et al., 2014).

These are of course simplified caricatures of KCs which are highly complex and overlap to some degree in their espousing of the inclusion of differing types of knowledge. Knowledge contexts can be viewed as socially constructed, perpetuated via language and social practices (Gergen, 1999) and potentially serving multiple agendas. Thus students not only navigate between physical settings (classroom to ward) and social environments (student cohort to ward team), but also between diverse KCs – with their inherent discourses of what is useful or valuable knowledge and consequentially diverse approaches to 'practice'.

Study 1: Re-contextualising knowledge as a newly qualified nurse

In Study 1, into NQNs' experiences of their transition from senior student nurse to registered nurse (Magnusson et al., 2014), only a few NQNs were able to describe an awareness of their learning. Thirty-three newly NQNs working in three different acute hospitals in England participated in the study. The nurses were based in general medical, surgical and accident and emergency in-patient wards.

Mostly NQNs described the early months of their registered practice as a 'muddle' and a 'struggle'. NQNs described an almost text book case of re-contextualisation, for example, knowing the knowledge was there and being able to pull things together from wherever it was stored, while at the same time not necessarily knowing what it is to be a nurse.

Many NQNs found it difficult to identify and access the knowledge that they needed in the early days of practice to organise and delegate care. However, NQNs were able to articulate a perception of things fitting into place, usually after some six months of practice. In other words a re-contextualising moment, which suggests some resolution to a difficult learning period, which implies new knowledge.

While the re-contextualisation of knowledge may occur over time NQNs identified the stress related to being newly qualified. Furthermore finishing one's workload on time is contingent upon adequate staffing, which suggests that more learning remains in order for newly qualified nurses to feel like an independent and competent practitioner.

This finding conveys how difficult learning is as an NQN. It seems the muddle described by the NQNs is caused by strong emotions arising from the struggle to organise themselves, prioritise care and supervise health Care Support Workers (HCSWs). NQNs learn through the fear of mistakes or the observation of others' mistakes.

Learning through mistakes

The fear of making a mistake is quite striking. Findings from Study 1 illustrate NQNs often perceive fears regarding what could go wrong. However, facing these fears allows NQNs to reflect, and to 'step back'. While this doesn't seem to be an example of re-contextualisation in

that reflecting on feelings of fear didn't appear to result in an awareness that such fears are manageable, which would suggest new knowledge. It would appear from these data from Study 1, that re-contextualisation may not always result from reflection as the emotions may not be processed. Somehow the emotions interfere with re-contextualisation. This may be because learning through mistakes evokes emotions which are powerfully uncomfortable and stressful and NQNs may not have any support to process them (Johnson et al., 2014).

The fears observed during fieldwork in clinical areas, followed by informal conversations with NQNs in practice illustrates how NQNs are often 'nervous' of the responsibility embedded within the new role, for example fears that patients will die. Moreover, when NQNs supposedly `learn` through others' experiences this does not necessarily equate with less anxiety. Furthermore, there is no evidence of reflection or re-contextualisation. The NQN in Study 1 who reported feeling unsafe (nervous), felt an overwhelming feeling of responsibility, which needed to be borne alone, especially in circumstances where patients had died unexpectedly, with no explanation or context. When knowledge is not re-contextualised and the student and NQN lack the emotional safety to learn (argued here to happen much of the time) the consequences for the learner are potentially further mistakes, further muddling through and huge amounts of anxiety and fear. This, in turn, blocks developing authority, being accountable, finding one's voice as a delegator, developing confidence and competence.

Unsafe learning

Data from Study 1 suggests that NQNs had to learn from negative experiences, trial and error, as well as using untested strategies. Although most of the mistakes recounted by NQNs were minor, there were some examples of more serious mishaps. For example, one event was described by a nurse who had trusted an HCA to check that the patient going to theatre had the correct name on the wristband, and therefore just signed off the paperwork. While NQNs' learning is invisible as it is generally unprocessed or un-reflected upon (Allan et al. 2015; 2016a). However there is evidence of at least an awareness among mentors and ward managers that NQNs should be supported to learn as they settle into their new roles.

Emotional safety and support

NQNs also described learning through watching how more senior staff performed, explicitly learning in a supportive nursing team. For example, one NQN in Study 1 described a sense of awareness that support is available from nursing team members both registered and unregistered care staff. When reflection on fear of making mistakes occurs a new awareness based on new knowledge follows.

NQNs also described learning through watching how more senior staff performed, explicitly learning in a supportive nursing team. An awareness of support was not always present in the interview data but where it was described, it indicates firstly, an awareness of emotions in learning on the part of the NQN and shows an ability to re-contextualise learning. As Steven et al. (2014) suggest, an emotional safety for learning.

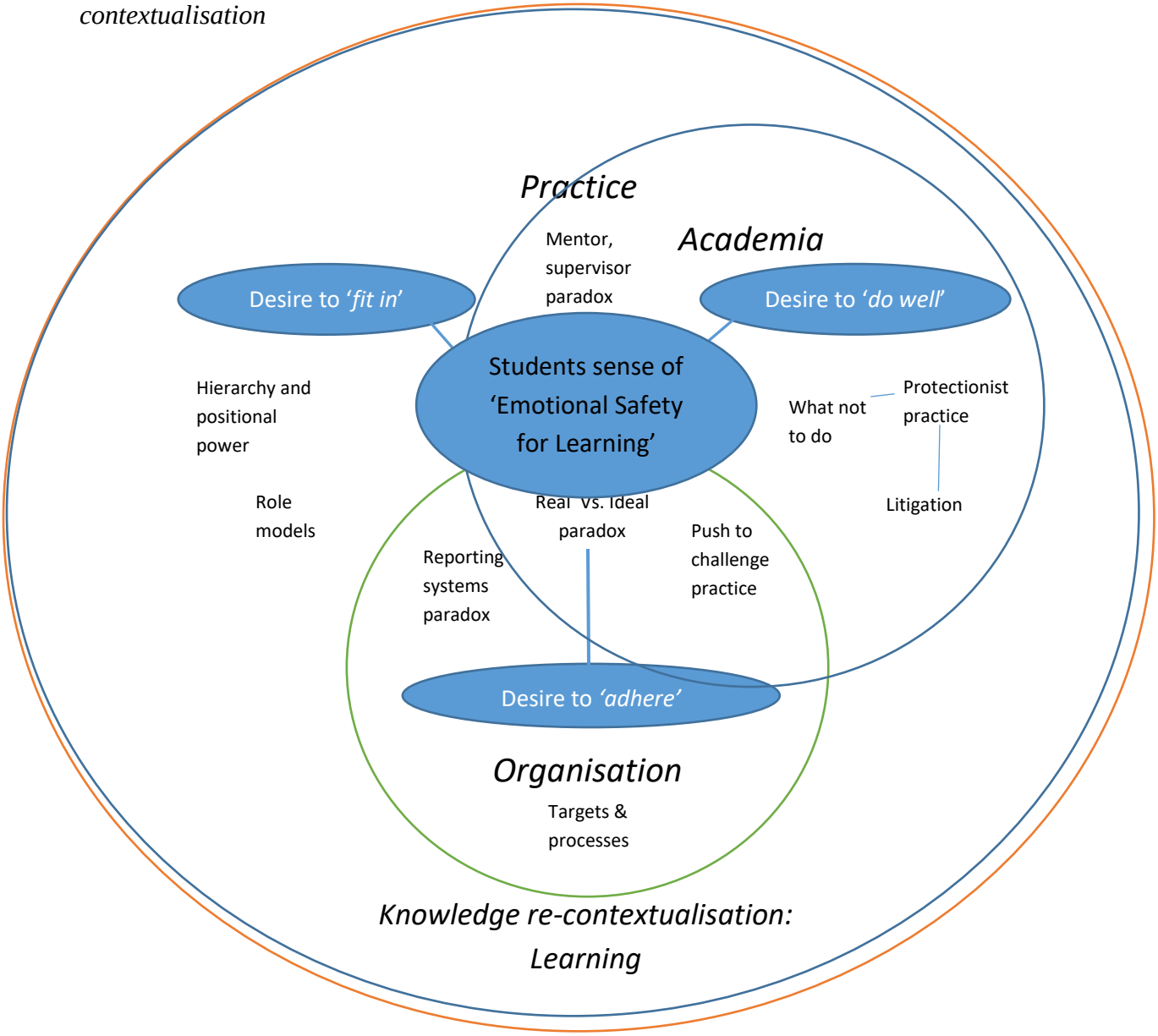
Study 2: Emotional safety for learning

Emotional safety for learning (ESFL) can be described as a 'milieu' or ambiance in which the learner (student, NQN or nurse undertaking CPD) feels able to question, comment, seek clarification, sensitively challenge and be challenged in a supported, facilitated way without fear of repercussions or penalties (Steven et al., 2014; Steven et al., 2018). Such an ambiance of ESFL would also lend itself to the surfacing, discussion and processing of emotions – those of the students and perhaps of others (patients, relatives and other staff). Core elements or mechanisms in the development of ESFL appear to include reciprocity, relevance and interactivity, which encourage feeling relaxed and safe to discuss concerns, experiences and areas of uncertainty (Steven et al., 2018). We contend that the presence of ESFL may enhance knowledge re-contextualisation (see following sections for illustrations).

Although ESFL may be experienced by pre and post registration nurse students (Steven et al., 2014; Steven et al., 2018), it is arguable that pre-registration students feel this much more acutely. Unlike qualified nurses engaged in continuing professional development (who are already professionally socialised), pre-registration students face the complexity of learning to traverse unfamiliar settings, cultures, and knowledge contexts; working with complex nursing teams; while also learning to work with feelings, undertake critical self-reflection and re-

contextualise knowledge. In addition, a series of issues, tensions and paradoxes in nurse education appear to further influence a learner feeling ESFL (see diagram1).

Diagram 1: Knowledge contexts, Emotional safety for learning and knowledge re-contextualisation



Tensions and dilemmas influencing ESFL

Steven (2009) has suggested that students need to believe in the education type or practice they are involved to maintain motivation. In the academic context, such motivation may be exhibited in a general desire to achieve good grades or do well. Indeed Dörnyei's (2000) student motivation model describes an 'actional' phase (e.g. during the course or task) which includes

a process of 'ongoing appraisal' in which students evaluate a multitude of environmental stimuli as a means of judging and monitoring their progress towards their goal. Likewise in the practice context the student may instinctively wish to 'fit in' or 'belong'. In relation to the organisational context, (and dependent on exposure and permissions) students may feel that if they do engage with organisational systems (such as incident reporting) they need to adhere closely to them- to follow procedure. These desires to fit in, do well and adhere may be present in and across all knowledge contexts to differing degrees and may influence the dilemmas and tensions felt with a knock on effect for their sense of ESFL. Some of these dilemmas and tensions will now be illustrated using data from Study 2.

Protectionist practice

It was evident from Study 2 that in the academic setting students were taught 'protectionist' practice. Curriculum documents and academic staff emphasised the importance of professional registration and the code of conduct. For example, academic staff reported teaching about professional standards, professionalism and clinical governance from the beginning of the programme, as being driven by the requirements of the professional code.

However, students in Study 2 also noticed implicit messages from the hidden curriculum about what not to do, with an underlying sense of the risk and fear of losing registration signified by the NMC pin number.

Such caution may be seen as implicitly and insidiously portraying patient safety as predominantly related to the risks of practice - independent of the type of practice involved, and may have a detrimental effect upon the students' self-confidence, encouraging fear and tentative 'protectionist' practice. This tension may then influence students' sense of ESFL when in practice. Indeed students in Study 2 and NQNs in Study 1 struggled emotionally with the wish to put their academic context learning into practice (re-contextualisation) whilst facing: the messy reality of clinical practice; pressures of protectionist practice; compounded by their positional power (or lack of) in the nursing hierarchy.

Hierarchy and power

Hierarchy was also evident with both NQNs and students in Study 2 perceiving it impossible to question or challenge someone more senior. Thus the issue of questioning or challenging

practice was a dilemma and major tension for the students, and indeed such challenge was in some ways encouraged and reinforced by the university who espoused principles of evidence based best practice. This created dissonance for the student: a potential burden of guilt for not using correct techniques and further feelings of not 'belonging' which conflict with their desire to fit in. A sense of struggle and dissonance was evident in the reported discourses of students and NQNs. This burden and hierarchical position was compounded when students and NQNs perceived a need to be accepted into their new roles.is also evident in the extract in box 6 where the 'mere student' hints at the hierarchy at play and the lack of positional power compounded by the desire to fit in.

Role models

The issue of questioning, querying or challenging was never more present than in relation to role models, and while there were many good role models nevertheless, those who were perceived as 'poor' by students and NQNs in Study 2, seem to have been highly influential. For example, the perceived issue of a gap between theory and practice was justified by qualified nurses, in other words more senior staff, whereby `corners were cut` in the name of expediency.

Witnessing this practice and feeling unable to challenge may heighten the emotional burden for the student (thus negatively impacting on their ESFL) who is fearful of challenging, wants to fit in and perceives their position as being at the bottom of the hierarchy. In response to the perceived difficulties in questioning, exploring or challenging practice an alternative approach is that of a need for assertiveness education. However, it could be argued that such assertiveness education or training may have the tendency to 'individualise' the issue, making it the problem of the student or NQN. Such an approach (as often present in discourses of resilience) removes the focus from wider systems, culture, community of practice and so on, and fails to also consider the need for students to learn to re-contextualise knowledge and develop understandings of practice as enacted.

Mentor/supervisor paradox

A further important tension which can be viewed as heavily influencing ESFL regards the relationship between a student and the person assigned as 'practice mentor' or educational supervisor. An ideal educational relationship could perhaps be viewed as a relaxed relationship where it feels ok to disclose and discuss concerns, experiences and areas of uncertainty and to question and challenge. In essence such a relationship would ideally engender trust, facilitate

interactivity and reciprocity (Steven et al., 2018). However, while qualified nurses in Study 1 acknowledged the need for such a trusting relationship, students were cognisant of the variation which existed, reporting practice learning to be variable depending on the practice placement, on whether or not the mentor is motivated to teach. Moreover, the students often would not know in advance the nature of the mentor/student relationship.

The desire for an effective educational relationship was compounded by the need to fit in and do well, the students place in the hierarchy, and conditioned by the awareness that practice mentors were reported in Study 2, to be solely responsible for assessing placement learning and 'signing off' competencies. A paradoxical situation seemed to exist where the mentor had a dual role: facilitating learning and also assessing or grading practice based elements of the pre-registration course. Students often felt conflicted and were therefore reticent about raising and discussing any issues that may potentially influence their grades- be they emotional issues or questions about practice.

Reporting systems paradox

A further paradox existed regarding the organisational reporting systems, which were espoused as promoting an open culture, encouraging reporting and learning from errors and mistakes. However such systems also served (and it could be argued still serve) as a mechanism for identifying underperformance. Thus, the systems embody what has been called the 'dual imperatives of accountability and organizational learning' (Dodds & Kodate (2011, 328). Although the students may not have engaged directly with these systems they may have been aware of staff scepticism and mistrust of the systems through throw away comments and remarks. This feeling of organisational mistrust, whether conscious or not, could again impinge on decisions to challenge, question or report aspects of practice they may have perceived as unsafe.

Discussion

In 1964, in a national study in the UK, Revans (1964) was able to demonstrate a clear association between an infrastructure for care and positive staff and patient outcomes. He showed that organizations with high morale had effective communication systems where ward sisters spoke frequently with junior nurses, were able to retain a stable workforce and consequently showed better than average patient recovery times than in comparable hospitals.

The caring organization therefore, is one that engenders high morale which in turn sustains and supports the delivery of frontline care (Smith et al., 2009). Any consideration of emotional safety for learning and organisations (Smith et al., 2009) needs to account for the connections between how staff are managed, how they feel about their work and the outcomes for patients (West & Dawson, 2013). The complex relationship between staff and patient safety, emotions at and the impact of these two complex factors on quality of care is highlighted by quantitative and qualitative studies spanning two decades in both the UK and US (Woodrow & Guest, 2008). Unfortunately, research shows that emotional safety for learning is not the normative experience of nursing students and NQNs in the English NHS; in fact, as Melia (2005) has argued, the NHS is not a learning organisation.

We have explored how the theory of re-contextualisation could help students learn across a disintegrated learning context during their preparatory professional nursing programmes. In this chapter, we have integrated work on *emotions and learning* (Smith & Allan, 2010; Allan, 2011; Allan, 2016) and *emotional safety for learning* (Steven et al., 2014), to argue that re-contextualisation may be developed as a useful theoretical framework to understand student nurses' and NQNs' requirement for emotional safety in order to learn. We have explored how emotional safety might support current workforce developments in increasingly complex nursing teams. Such an approach to learning (that learners need to feel emotionally safe to learn and that learning occurs across settings and is context dependent) at this stage of a professional career (as students transition to NQN) may be a way to resolve tensions for students and NQNs which 'splits' their thinking about different practice priorities. In both studies, participants (students and NQNs) reported tension between their understanding of the NMC code which is reinforced frequently in their university teaching and written work, and their observations of ward team customs and practices which do not meet the NMC code. This frequently led to 'splits' in their thinking. This might be described as a split between HEI and practice which is talked about as the 'theory-practice' gap (Smith & Allan, 2010) but in reality is an emotional splitting which is frequently manifested as anger towards either practice colleagues or lecturers (Allan, 2011). Both Steven et al. (2014) and Allan et al. (2015; 2016a; 2017) have shown that students and NQNs learn how to bring together the reality of making decisions within local workplace custom and practice – accountability – with what they've been taught about ideal practice in HEIs but sometimes at a cost (Allan, 2011; Allan et al., 2017). An example of how this split is reproduced in students and NQNs' talk is the way they talk about 'losing their PIN

(personal identification number)'. In both studies, students and NQNs described tutors scaring them with 'horror' stories about losing their PIN through unprofessional practice. Data from both studies suggest that this talk of losing their PIN can inhibit students and NQNs from learning. The emotions evoked by being fearful of losing their PIN are rarely acknowledged. This lack of emotional processing has been found before in health care professionals' practice. Emotions are rarely referred to when talking (and writing) about the work that is done in healthcare (Taylor, 2006; Allan, 2011) and descriptions of work are often bland (Fineman, 1993). Yet emotions abound and are the crux of errors and patient safety incidents (Smith et al., 2009); learning from these and effective communication in teams is integral to becoming confident and competent as an NQN (Allan et al., 2017).

The Francis report highlighted the importance of proper support and supervision for healthcare support workers (HCSWs), to ensure they are not just 'left to their own devices', potentially exposing patients to unacceptable risks (Francis, 2013). The Francis report also indicated a need for more effective delegation by nurses in relation to HCSWs. However, despite the increasing relevance of delegation and supervision skills among nurses, these do not yet form a central component of nurse training or preceptorship programmes (Allan et al., 2015; 2016a; 2017). With increasing pressures on NHS resources and the introduction of nursing associates and apprentices, there will be more reliance on streamlining tasks and roles between nurses and their support workers in nursing teams. Maximising these clinical teams' performance via effective working between them, and in particular, appropriate task allocation and completion respectively, will form a crucial component in safe and efficient patient care and outcomes. These workforce changes currently place great demands on *students* as they observe what their future roles may involve and on *NQNs* as they begin to take responsibility for new nursing teams. We argue that greater focus be given to creating emotionally safe learning spaces for both students and NQNs in curricula.

We have argued that:

- In addition to the individual ability to critically self-reflect and re-contextualise knowledge when working in complex nursing teams, students and NQNs require a learning culture which encourages 'emotional safety'.
- Learning to work with feelings or 'emotional learning' is enhanced by understanding how the learning takes place across such environments and contexts.

- Students and NQNs traverse and negotiate a range of physical and social environments and ‘knowledge contexts’.

Conclusions

In this chapter, we have argued that students and NQNs need emotional safety in order to re-contextualise or learn across knowledge contexts – learning is the production of new knowledge, which allows students and NQNs to develop in their journey to independent and competent practice as a registered nurse. We have illustrated our argument with extracts from two large scale qualitative studies from the UK. We have shown how safe challenge in the clinical learning environment can contribute to the development of a skilled reflective professional.

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